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AGING VETERANS IN AN AGING SOCIETY
PUBLIC POLICY AT A CROSSROADS

A REPORT

PRESENTED BY

THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

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FOREWARD

American society is undergoing a change in age structure that has been popularly labeled the "graying of America." Since the turn of the century, older persons have become an increasingly larger segment of the population -- a trend that will continue for at least the next 50 years. In 1980, some 25.5 million persons - approximately 11.3 percent of the American population - were age 65 and older. By 2030, this age group will increase to 64.3 million and will comprise 21.1 percent of the population.

For one segment of American society - the population of veterans - the dramatic shift in age structure will occur even sooner.

The purpose of this report is to describe the nature and policy implications of growing numbers of older veterans in the context of an aging society. It is also to chronicle recent events that have led to significant reforms in veterans eligibility with the passage of the Omnibus Reconciliation Act of 1985 (H.R. 3128) and that have brought the historically separate veteran and non-veteran health care systems to a crossroads in public policy. That being, how best to address the health care needs of increasing numbers of older veterans and older persons at large.

The intention of the House Select Committee on Aging in releasing this report is to educate the American public as well as professionals, policy-makers and advocates concerned for older persons on the challenge and opportunity that an aging veteran population presents to the nation as a whole.

It is also to draw attention to the common stake of all Americans in meeting the challenge of the older veteran and preserving the nation's commitment to those who have served.

Finally, it is our intention to encourage greater communication and collaboration between traditionally separate VA and non-VA health and social service systems in the interest of older veterans and non-veterans alike.

As the Chairman of the Aging Committee, I wish to extend my appreciation to the Congressional Research Service, and to Ms. Barbara McClure in particular, for assistance in drafting substantial portions of this report.

Edward R. Roybal, Chairman
House Select Committee on Aging

April, 1986

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CHAPTER I
INTRODUCTION

The Challenge

The aging of American society presents a serious challenge for the nation's health and social welfare systems. While advances in medicine and changes in lifestyle have improved the overall health of today's elderly and extended their productive years, older persons remain at higher risk of costly acute and long term catastrophic illness than their younger counterparts. At the same time, older Americans have only limited protection through Medicare and private insurance against the costs of health care -- costs which now account for 15% of the elderly's fixed resources and, based on Committee estimates, could rise to 19% of their income by 1990.

Of particular significance is the elderly's risk and lack of financial protection against the costs of chronic illnesses requiring extended nursing home or home health care. Currently, there exists no public policy on long term care except under Medicaid for the poorest of poor and under the VA health system for service-connected veterans and indigent nonservice-connected veterans. Further, private insurance options for long term care are limited, costly and still in the early stages of product testing. This leaves elderly persons needing long term care services at serious financial risk of rapidly spending down a lifetime of savings to the level of Medicaid - a level well below the poverty line.

The challenge the elderlys' health and related financial risk presents to the nation is significant and is further compounded by their growing numbers. By the year 2030, the number of persons aged 65 years and older will nearly triple from the 1980 level of 25.5 million to 64 million.

One important component of this challenge - the population of American veterans - is aging at an even faster rate than the general population as the largest group of veterans, World War II veterans, approach the average age of 65. By the year 2000, the number of veterans age 65 and over will triple from three million in 1980 to nine million. By the year 2000, two out of every three American males over age 65 will be veterans. The veterans health care system, therefore, is already faced with the pressures of a rapidly increasing elderly population some 20 to 30 years before the nation as a whole.

Concern over the VA's ability to meet projected demand led to significant reforms in veterans eligibility and cost-sharing in 1986. Reforms legislated in the "Consolidated Omnibus Reconciliation Act of 1985" (H.R. 3128, passed March 20, 1986) identify which veterans the VA will serve as a matter of policy, and mandate that they be provided care in VA facilities. Prior to H.R. 3128, all low income veterans were potentially eligible for free health care from the Veterans Administration (VA) as resources were available. Similarly, all veterans age 65 and over were eligible for VA medical care regardless of financial need and to the extent that VA resources were available. With H.R. 3128, the population of veterans which the VA must serve is more clearly defined and provisions are made for cost sharing based on a means test for eligible veterans of all ages.

While the reforms introduced by H.R. 3128 permit the VA to target its services to a defined and limited number of veterans, it has yet to be seen whether this will solve the anticipated problems of demand which these reforms were designed to preclude. Demand for VA care by veterans may continue to increase due to the increased numbers of elderly veterans and the higher utilization rates associated with old age.[1] Furthermore, demand could be further increased with current and future cutbacks in benefits and increased cost-sharing requirements under other medical care programs such as Medicare and Medicaid. Such cost-containment measures may result in more veterans turning to the VA for care who had not elected to use the system in the past.

With the reforms introduced in H.R. 3128, those nonservice-connected veterans who are not eligible for free care from the VA or who choose not to use the VA health system - the vast majority of all older veterans - will continue to rely in greater numbers on their own resources and on other public programs for their health care needs. These veterans, like their non-veteran counterparts, will find little in the way of public or private financial protection against the costs of catastrophic and long term illnesses. So too will they find their limited resources quickly depleted when this type of care is needed. Hence, the protection of veterans outside the VA system, together with older non-veterans, becomes a broader issue of national policy.

Added to the challenge of increasing numbers of older veterans - despite the eligibility reforms of H.R. 3128 - is their increased need for acute and chronic, long term health care. This requires that the VA not only plan for greater numbers of older patients, but also for the potential extension of a heavily acute and medically-oriented system to include a greater emphasis on comprehensive, chronic long term care services. The implications of this added focus - one shared by the non-VA sector as well - are significant from the standpoints of technology development, manpower training, research, service delivery, and costs.

Constraints in Meeting the Challenge

Despite compelling need, no comprehensive national policy on health and long term care for older Americans has emerged. While a variety of federal, state and local programs for the elderly have been developed in recent years, they have evolved in largely a piecemeal and uncoordinated fashion -- leading to variation and gaps in service coverage.

On the non-VA side, the federal government provides medical care and social services to the elderly primarily through four programs: Medicare, Medicaid, the Older Americans Act, and the Social Services Block Grant. These programs provide various services - sometimes overlapping but generally with different eligibility requirements - for varying population groups. Although attention has been given to the need to solve problems of service coverage, coordination efforts to date have been largely limited to demonstration projects and some state and local initiatives.

The VA system offers a more comprehensive array of health, social and economic services to veteran beneficiaries than do other federal programs. However, it yet to be seen whether the current level and scope of the VA's long term care services will be adequate to meet growing demand for this type of care.

The reality of growing numbers of older veterans together with budgetary restrictions has led not only to reforms in veteran eligibility, but to consideration of the need for greater service coordination between the VA and non-VA sectors as well.

Just as the nation tackles the serious problem of a rapidly aging society, budgetary concerns have reached crisis proportions. Added to the challenge of growing numbers of older persons are budget cuts already imposed under the "Balanced Budget and Emergency Control Act of 1985" (P.L. 99-177, popularly known as the "Gramm-Rudman-Hollings" legislation, enacted December, 1985), and more serious cutbacks anticipated in the move toward a balanced budget by 1991. As a result, the need for health care cost containment measures across VA and non-VA programs has heightened -- leading to reforms in service eligibility and coverage and renewed attention to opportunities for coordination of VA and non-VA community services.

The collective effect of eligibility reforms and budget savings measures on VA and other public programs has yet to be seen. However, in the short term, veterans and non-veterans alike are likely to feel the pinch of cost containment on all sides. What this portends for the future depends, in part, on the ability of planners and policy-makers to factor the interactive effect of these traditionally parallel health care systems into responsible service and policy decisions.

Implications and Opportunities

The upcoming surge in the aged population, budgetary constraints and the resulting challenge to both the VA and non-VA health systems have led to serious examination of the interaction of VA and non-VA policies as well as opportunities for collaboration between VA and non-VA programs.

Conferences and congressional hearings on these issues have been held; the Administration proposed a restrictive means test for non-service connected veterans of any age; a more liberal means test and eligibility proposal was been passed by the Congress under the "Omnibus Reconciliation Act of 1985" (H.R. 3128); and a law was recently enacted (P.L. 98-160) authorizing the VA to enter into sharing arrangements with community programs providing adult day health care.

The potential interaction of VA and non-VA health care policies and service systems raises a number of questions that may frame the debate over how and to what extent this country will provide for the needs of older veterans and non-veterans alike.

- To what extent will the absence of any national policy on long term care combined with increasing cost containment pressures on the non-VA public sector drive more and more eligible veterans to the VA for care?

- Conversely, will veterans come to rely on a less comprehensive care system due to changing eligibility and limited service capacity within the VA? Will this serve to pit veterans and non-veterans against one another?

- What cost transfers will occur on both sides of the service system as the elderly's out-of-pocket costs increase to the point where they are unable to pay for needed care -- forcing them to turn to the public sector sooner for support.

- To what extend will cutbacks in public programs that protect America's aged veterans and non-veterans be shifted to the elderly person and their family? In the case of chronic care, what impact will this have on family security and on federal and state spending as families spend down to Medicaid?

- What will be the impact of program cuts and cost containment measures on the aged veteran's and non-veteran's access to acute and long term care?

- Will recent reforms in VA eligibility be successful in preserving the public's commitment to those who have served their country - America's veterans?

- What will the public's commitment be to protecting all aged Americans at financial risk due to the uncovered costs of acute and long term care -- Americans that include some 80% of all aged veterans who will never go to the VA for care?

It is questions such as these that will need to be carefully considered in assessing the impact of recent and future policy reforms within and between VA and non-VA health and social programs. It is questions such as these that have and will continue to draw policy-makers, providers and advocates of VA and non-VA health care systems together on matters of common concern. And, it is questions such as these that will only heighten the role of congressional stewards of the VA system in preserving the veterans' trust.

As Dr. Donald Custis, former Chief Medical Director of the Veterans Administration, stated at a recent Harvard University conference on VA/non-VA community coordination:

> "The aging veteran is but a part of a larger component, namely the graying of America. The magnitude of the socioeconomic and medical needs of the older veteran cannot be served with VA resources alone, nor can a VA geriatric plan be pursued in isolation from the rest of society."[2]

The challenge older veterans present to the nation is also an opportunity. Because the VA will experience the "older population explosion" before the country as a whole, and because of the VA's unique status as a single, comprehensive health care system, the VA will have much to offer as a "testing ground" for the development of innovative health care and related programs for all older Americans. To the extent that advocates, providers and policy-makers for older Americans realize this potential, the country will be better prepared to meet the needs of its older citizens today and in the future.

What follows is a review of the demographics of an aging veteran population and an aging society; a review of the projections of the demand for VA health care that led to recent eligibility reforms; and a discussion of policy options for addressing the challenge facing the VA and non-VA health care systems. A summary of the VA system and the VA's legislative history is also included in Appendix A.

CHAPTER II
THE AGING POPULATION
NUMBERS, HEALTH AND FINANCIAL RISKS

The U.S. Population

In 1900, about 3.1 million persons--4.0 percent of the total U.S. population--were age 65 and over. By 1980, persons age 65 and over totaled 25.5 million and comprised 11.3 percent of the population. The Census Bureau projects that by the year 2000 the 65+ group will grow by one-third again to 35 million. Following 2010, due to the aging of the baby boom generation, this age group will grow even faster, rising by the year 2030 to 64 million, or about 21 percent of the population--an increase of 152 percent over 1980.[3]

Even more dramatic are projected increases for the age groups 75-84 years and 85 years and older (the "old-old"). The 75-84 age group is projected to increase from 7.7 million to 21.1 million--173 percent--between 1980 and 2030. The 85+ age group will quadruple from 2.2 million in 1980 to 8.8 million in 2030. Table 1 shows the projected growth of the elderly population for the years 1980-2050.

The Veteran Population

Large increases in the number of aged among the veteran population are occurring sooner than among the U.S. population as a whole because veterans are clustered in age cohorts that correlate to periods of war. Although during peacetime there is a steady stream of service members leaving the armed forces, the number of peacetime veterans is small compared to the number of veterans of major conflicts. In 1984, there were approximately 28.1 million living veterans in the United States and Puerto Rico, 22.9 million (81 percent) of whom were war veterans.

TABLE 1. Projected Growth of the Older Population: 1980-2050
(in thousands)

Year	Total U.S. Population	65 to 74 Years Number	%	75 to 84 Years Number	%	85 Years and over Number	%	65 Years and over Number	%
1980	226,505	15,578	6.9	7,727	3.4	2,240	1.0	25,544	11.3
1990	249,731	18,054	7.2	10,284	4.1	3,461	1.4	31,799	12.7
2000	267,990	17,693	6.6	12,207	4.6	5,136	1.9	35,036.	13.1
2010	283,141	20,279	7.2	12,172	4.3	6,818	2.4	39,269	13.9
2020	296,339	29,769	10.0	14,280	4.8	7,337	2.5	51,386	17.3
2030	304,330	34,416	11.3	21,128	6.9	8,801	2.9	64,345	21.1
2040	307,952	29,168	9.5	24,529	8.0	12,946	4.2	66,643	21.6
2050	308,856	30,022	9.7	20,976	6.8	16,063	5.2	67,061	21.7

Source: U.S. Department of Commerce, Bureau of the Census. America in Transition: An Aging Society. Current Population Reports, Special Studies, Series P-23, No. 128. Revised December 1983. p. 3.

The largest wave of living veterans is the 10.8 million World War II veterans who, in 1984, comprised about 39 percent of the total veteran population. Their median age in 1984 was 62.8 years. Korean Conflict veterans totaled 4.2 million (about 15 percent of the veteran population) and were an average age 52.5 years in 1984.[4] The 7.6 million Vietnam Era veterans comprised 20 percent of the veteran population and were average age 36.8 years in 1984.[5] The average age in 1984 of the 272,000 World War I veterans was 87.8 years (Table 2).

Assuming no future U.S. involvement in major conflicts, the total number of veterans will decline over the next several decades. The 1980 veteran population of 28.6 million will decrease to 24.3 million by the year 2000 and to 17.5 million by 2020.[6]

Despite the decline in the total veteran population, the number of older veterans will increase. It is projected that the number of veterans age 65 and older will triple from three million in 1980, to nine million by the year 2000. Following 2000 the number of older veterans will begin to increase. In 1980 veterans age 65 and over comprised 10.6 percent of the veteran population; by 2000 they will comprise 37 percent and in 2020 nearly 45 percent. (Table 3.)

Of particular significance is the projected increase in the number of very old veterans--those 85 years and over--who in 1980 numbered about 220,000 and comprised less than 1 percent of the veteran population. By 2020 their numbers will increase to 1.37 million and 7.8 percent of the veteran population.[7]

At the same time that the numbers of old and old-old veterans will be increasing, so too will their composition change as women, minorities and ethnic groups increase as a proportion of all VA users. With this shift, the VA will need to be prepared not only for an older, chronic care population but also for a patient mix with potentially unique care need and service delivery requirements.

TABLE 2. Estimated Number of Living Veterans By Age and Period of Service, March 31, 1984
(in thousands)

Age	Total Veterans a/	Vietnam Era b/	Korean Conflict c/	World War II	World War I	Peace-Time
All ages	28,135	7,603	4,233	10,840	272	5,186
Under 25	492	--	--	--	--	492
25-34	3,636	2,500	--	--	--	1,137
35-44	6,020	4,737	--	--	--	1,283
45-54	5,958	344	3,524	162	--	1,927
55-64	7,656	22	676	6,826	--	132
65-74	3,396	1	25	3,265	--	104
75-84	709	--	7	555	53	94
85+	267	--	1	31	219	17
Median Age	52.0	36.8	52.5	62.8	87.8	44.0

a Detail may not add to total due to rounding.
b Not including those who served also during the Korean Conflict.
c Not including those who served also during World War II.

Source: Veterans Administration, Office of Information Management and Statistics. Veteran Population, Mar. 31, 1984. May 1984.

TABLE 3. Projected Changes in the Veteran Population: 1980-2020
(in millions)

Year	Total Veteran Population	65 to 74 Years		75 to 84 Years		85 Years and over		65 Years and over	
		Number	%	Number	%	Number	%	Number	%
1980	28.6	2.18	7.6	.64	2.2	.22	0.8	3.04	10.6
1990	27.1	5.62	20.7	1.33	4.9	.21	0.8	7.16	26.4
2000	24.3	5.01	20.6	3.45	14.2	.52	2.1	8.97	36.9
2010	20.7	3.72	18.0	3.02	14.6	1.38	6.7	8.13	39.3
2020	17.5	4.05	23.1	2.35	13.4	1.37	7.8	7.77	44.4

Source: Veterans Administration. Caring for the Older Veteran. Washington, D.C., July 1984. p. 16.

In 1980, only 1.1 million veterans (3.9 percent) were women. By the year 2020, although the absolute numbers of older women veterans are expected to remain small (1.3 million) this is an 18 percent increase above the 1980 level -- reflecting the increasing enlistment of women in the armed forces since the Vietnam War.[8] The growing percentage of women veterans takes on added significance for the VA in light of their increased longevity; the fact that older women are more frequently poor and lacking caregiver support than older men; and the disproportionate numbers of nursing home residents who are women in the community's experience.

Similarly, the enlistment of blacks, hispanics, asians, and other special population groups has also increased -- beginning with the Korean conflict and World War II, and increasing during the Vietnam era. The number of black veterans from the Vietnam era (733,000) is twice the number from the Korean conflict (373,000). Similarly, the number of veterans of spanish origin from the Vietnam era (344,000) more than doubled those from the Korean Conflict (148,000).[9]

Although little is yet known what effect increasing numbers of veterans in these groups will have on the VA health care system, a number of observations can be made. First, given the increased proportion of poor persons in minority and ethnic groups compared to whites, their numbers can be expected to account for an increasing proportion of VA users over time. Second, what studies have been conducted of black and hispanic veterans indicate that these patients experience greater difficulty accessing VA care than their white counterparts due largely to cultural and language factors.[10] Finally, as the VA attempts to meet the special needs of increasing numbers of black, hispanic and asian persons in the World War II wave of veterans, the experience will serve the VA well as the pool of Vietnam era veterans ages.

Health Care Implications of An Aging Society

Old age is not synonymous with illness, incapacity and dependency. As indicated previously, most older persons enjoy relatively good health and are able to care for themselves in their own homes. Contrary to popular belief, only about 5 percent of the elderly population live in nursing homes.[11] However, with old age there is a greater likelihood of illness, especially chronic illness, often resulting in infirmity and increased dependency. Almost 13 percent of the total aged population, and 22 percent of those over age 75, are in some way dependent on others in their daily living.[12]

Because the aging process is accompanied by increased dependency and incidence of chronic conditions, more episodes of illness, and longer recovery times, older persons consume a disproportionate share of the nation's health care resources. In 1984, people 65 years and older represented 12 percent of the population but accounted for an estimated 31 percent of health care expenditures. In 1981, about 18 percent of older persons were hospitalized as compared to 9 percent of those under age 65, and their average length of hospital stay was 10 days versus 7 days for younger people. People 65 and over averaged six visits to the doctor per year while those under 65 averaged four visits per year. Persons age 65 and older on average had their usual activities restricted because of illness or injury for 40 days in 1981. For younger persons, the average was 17 days.[13]

Similarly, older veterans account for a share of VA health care resources that is disproportionate to their numbers. Veterans age 65 and over currently comprise about 15 percent of the veteran population. The VA estimates that $3.3 billion of an approximately $8 billion medical care budget for fiscal year 1984 was spent on health care for the aged.[14] In 1983, 30 percent of VA hospital patients were 65 and over. The average age of veterans treated in VA nursing homes was 70.3 years; 63.8 percent were 65 or over. The average age of veterans treated in VA domiciliaries was 59.1 years; 27.9 percent were 65 or over. Table 4 shows the increase with age in utilization of VA facilities by age. (Table 4.)

TABLE 4. Utilization of VA Facilities by Age, 1982

Age	VA Hospitals		VA Outpatient Facilities		Nursing Home Census supported by VA per 1000 Veterans
	Users per 1000 Veterans	Discharges per 1000 Veterans	Users per 1000 Veterans	Visits per 1000 Veterans	
Under 45	13	18	74	356	.06
45-54	17	26	78	445	.30
55-64	26	42	121	715	.88
65-74	40	64	179	1020	2.48
75-84	64	100	251	1261	8.70
85 and over	84	125	235	1228	17.10

Source: Custis, Donald S. The VA Responds on Aging. Health Affairs, v. 2, winter 1983, p. 158.

The Economic Status of Older Americans

Compounding the problem of increased illness among the elderly is the fact that older people, most of whom have retired from the workforce, in general have lower, fixed incomes than do younger people. Census Bureau data indicate a "strong pattern of declining income associated with age."[15] In 1984 the median income of families headed by persons age 65 or older was $18,118, about 62 percent of the median income of families headed by persons age 25 to 64 ($28,972).[16] The median income of elderly individuals not living in families was $7,296, about half of that for non-elderly individuals ($15,561).

Elderly persons are more likely than other adults to be poor. If children are also considered, however, elderly poverty rates are slightly below those for the rest of the population. In 1984, 12.4 percent of persons age 65 and older had incomes below the poverty level, compared to 11.7 percent of those age 18 to 64 and 14.7 percent of all persons under 65. However, the elderly are much more likely than the nonelderly to have low incomes just above the poverty level. In 1984, 16.7 percent of persons age 65 and older were in families with incomes between the poverty level and 150 percent of the poverty level, while only 9.1 percent of those under age 65 were in families with incomes in this range.

While most older Americans have some coverage for health care costs through Medicare, Medicaid or private insurance, these sources are limited in their coverage of long-term care services (services from nursing home and other institutional care to community and in-home programs such as adult day care, home health or homemaker services) and increasingly transfer more and more of the burden of cost to the elderly beneficiary through higher premiums, deductibles and co-payments. Of the 27 billion spent each year on long term care alone, nearly half is paid for out-of-pocket by elderly patients and their families.

The costs of long term care in particular can reach catastrophic proportions and drive even middle income elderly into poverty rapidly and unexpectedly. A recent study of well elderly living in the community conducted for the House Select Committee on Aging showed that 63% of all elderly persons surveyed living alone would spend down their income and assets to Medicaid within 13 weeks if nursing home care was needed.[17]

Looking at total out-of-pocket costs over time, the elderly's total health care bill grew from 12 percent of their income in both 1977 and 1980 to over 15 percent in 1985 - more than where Medicare and Medicaid began. If current trends continue, this percentage will rise to 19% of their income by 1990.[18]

Recent studies have concluded that income and adequacy of insurance coverage are the most important determinants of a veteran's decision to use the VA system.[19] These studies tend to confirm the VA's contention that, for the most part, it serves a population without the resources to obtain care elsewhere.[20] The fact that the elderly in general are less likely than younger persons to have private health insurance or other income sufficient to pay for medical care, especially long-term care, increases the likelihood of greatly increased demand for VA care in the coming years. Recent surveys have indicated that most veterans age 55 and over believe they will not be able to afford good medical care over an extended period of time, and that as many as 60 percent say they would use the VA health system if they are eligible.[21]

The health-related financial risks of older Americans - veterans and non-veterans alike - are considerable. Despite these risks, more and more attention is being given to controlling government costs by tightening eligibility and increasing beneficiary contributions under VA and other public programs. What has yet to be seen is whether these actions will result in cost-transfers between these two public health care systems or cost-transfers to the beneficiaries themselves.

CHAPTER III
PROJECTIONS OF DEMAND FOR VA HEALTH CARE

Two recent studies - one conducted by the VA and one by the Congressional Budget Office (CBO) - project the future demand for VA health care and the resources that will be needed to meet that demand. While the VA's projections are higher than CBO's, both studies project significant increases, both in the demand for, and the cost of providing VA health care.

Considerable debate surrounds the findings of these and other analyses of demand for VA health care. Yet, they became central to arguments for and against VA eligibility reforms proposed by the Administration and subsequently liberalized with the passage of the "Omnibus Reconciliation Act of 1985" (H.R. 3128).

The role these studies played in the debate over VA eligibility reform and the role they will play in the future as baseline data for assessing the impact of these reforms justify their careful review.

Veterans Administration Report

The VA report, "Caring for the Older Veteran," was released in July 1984. The report resulted from more than a year's study and analysis throughout the agency. The report projects future needs for all of the VA's major departments, but the emphasis is on the Department of Medicine and Surgery and the future demand for VA health care.

The VA study attempts to measure and project to the future what it terms "real need" for VA health care. "Real need" is defined in the report as:

> "The levels of health care services required by eligible veterans who request VA care or who would do so if (i) they knew of their eligibility and of VA services and if (ii) the services were readily available." [22]

The VA's projections of future "real need" differ from those that project current use patterns to the future because the VA's estimates attempt to account for potential users who are not currently using the system.

To arrive at its assessment of real need, the VA used three different methodologies (or models of "real need"), all based on the assumption that the primary determinant of demand for VA health care services is a readily accessible supply of VA services. As a result, a range of projected need was determined for each of the major VA health care services and for construction, funding and personnel levels. The three projection methods used by the VA were:

(1) The district-based method, which projected future use of the VA system from actual use in the most highly-served VA medical districts (the assumption being that highly utilized districts are fulfilling real need);

(2) The metropolitan statistical area (MSA) method, which is similar to the district-based method and projected future usage from actual veterans' use of health care in the most highly-served metropolitan areas; and

(3) The Harris Survey-based method, which based projections on data from a VA-commissioned Harris survey of veterans age 55 and over. The report cautioned that implications drawn from the survey-based method should be "tempered by the fact that it is a survey of opinions rather than of actual behavior or knowledge."[23]

Among the report's major findings and recommendations are the following.

Hospital Care

Discharges from VA hospitals are projected to increase from the current level of about one million per year to about 1.5 million under the lowest projection, and to 2.8 million under the highest, by the year 2000. According to these projections the VA will have to be able to handle at least an additional 500,000 discharges by the year 2000. The study estimates that for the VA to accomplish this, there will need to be a 68 percent increase in the total number of available inpatient beds.

The report recommends that the VA strategy should be to increase its own hospital inpatient bed capacity by 27 percent, and that any gaps between VA-owned capacity and needed beds should be filled by leasing or purchasing facilities or through contract care. According to the report, gaps in needed beds should begin to diminish after 1990 and disappear by 2020. The report also proposes that by 1990, special geriatric evaluation units (interdisciplinary teams that assess the full range of medical, functional, psychological and social aspects of geriatric patients) should be established in 70 percent of the VA hospitals, and by 2000, in 100 percent of the system's hospitals. (Table 5.)

TABLE 5. VA Inpatient Hospital Care: Projected Discharges
(in millions)

Method	1990	2000	2010	2020
District method	1.42	1.54	1.43	1.20
Metro area method	1.89	2.05	1.91	1.60
Harris survey method	2.31	2.82	2.52	2.10

Source: Veterans Administration. Caring for the Older Veteran. July 1984. Part I, p. 15.

Ambulatory Care Services

Under the VA's three projection methods, the need for ambulatory care in the year 2000 will range from 26 to 33 million visits (including both visits to the VA and elsewhere at VA expense), as compared to the current level of about 19 million per year. The report calls for the VA system of outpatient clinics to be expanded by the year 2000 to handle a minimum of 26 million staff and fee visits. In addition, it proposes that by 1990, specialized services for geriatric patients ought to be available in any outpatient clinic with significant numbers of such patients, and that by 2000 every outpatient clinic should operate a comprehensive medical assessment program in cooperation with a specialized VA geriatric evaluation unit. The report also proposes that by 2000, all eligible veterans should have access to outpatient services (whether a full service VA clinic, contract clinic, satellite clinic, MediVan, etc.) within one hour's travel time from their residences. (Table 6.)

Institutional Extended Care

VA projections of need for institutional extended care (i.e., nursing home and domiciliary care) in the year 2010 - the projected peak year for such demand - ranges from a low of 108,000 to a high of 139,000 average daily census, as compared to the current average daily census of 40,000. These numbers include patients in VA operated nursing homes and domiciliaries, in VA-supported State veterans homes and domiciliaries and in community nursing homes at VA expense. To meet this projected need for institutional extended care by 2010, the report states that VA operated, supported or contracted nursing home beds would have to be increased by at least 175 percent over 1985 levels. (Table 7.)

TABLE 6. VA Ambulatory Care: Projected Staff and Fee Visits
(in millions)

Method	1990	2000	2010	2020
District method	25.3	25.7	23.1	19.5
Metro area method	32.1	32.7	29.3	24.7
Harris survey method	29.5	31.4	28.9	25.8

Source: Veterans Administration. Caring for the Older Veteran. July 1984. Part I, p. 15.

TABLE 7. VA Institutional Extended Care: Projected Average Daily Census
(in thousands)

Method	1990	2000	2010	2020
District method	69	97	108	98
Metro area method	88	124	139	126
Harris survey method	63	102	119	106

Source: Veterans Administration. Caring for the Older Veteran. July 1984. Part I, p. 15.

Noninstitutional Extended Care

Because noninstitutional extended care (i.e., adult day care, hospital based home care, etc.) has not been extensively available in the VA to date, there was not sufficient data to use the three-projection approach. Instead, an alternative method based on one developed by the Department of Health and Human Services was used. A need for noninstitutional extended care for 460,000 veterans is projected for 1990, rising to 760,000 by 2000, then dropping off in the years following.

In FY 1985 an estimated 15,000 veterans will be provided with noninstitutional extended care services. The report recommends that by 1990, the number of hospital-based home care programs should be increased from the 1984 level of 30 to 76, and to 98 by 2000; that by 1990 the number of adult day health care programs should be increased from 5 to 40, and by 2000 to 98; and that by 1990 all VA medical centers and outpatient clinics should operate community residential care programs.

Health Care Operating Costs

The report estimates that for the VA to meet the projected real need for health care, the current health care budget of approximately $9.1 billion (for FY85) will have to increase to $13.6 billion under the lowest projection, or to $19.6 billion under the highest projection, by 1990. These estimates are in FY85 dollars, meaning they were adjusted for inflation and show real growth in expenditures, not a combination of growth and inflation. By the year 2000 the lowest of the projection methods shows an increase of 70 percent in real spending over FY85, and the highest projection showed spending for that year at a level more than two and one-half times the FY85 level. All projections show real spending declining after the peak year of 2000. (Table 8.)

TABLE 8. VA Health Care Operating Costs: Projected Budget Authority
(billions of 1985 dollars)

Method	1990	2000	2010	2020
District method	13.6	15.4	14.6	12.4
Metro area method	17.7	19.9	19.0	16.1
Harris survey method	19.6	24.3	22.4	19.0

Source: Veterans Administration. Caring for the Older Veteran. July 1984. Part I, p. 15.

Medical Construction

The report outlines a proposed construction strategy designed to assure adequate physical facilities for meeting the projected levels of demand for services. The proposed strategy calls for a major construction effort between the years 1990-2000. To avoid creating substantial excess capacity in later years, the report recommends that the VA should not attempt to build to meet demand in peak years but instead should plan new construction sufficient to meet projected needs for the year 2020. In this way the agency would be building for demand levels that will be sustained over a prolonged period.

In peak demand years the report suggests that any gaps between VA capacity and needed beds should be filled by leased or purchased facilities operated by the VA, or by contract care. The report states that the necessary private sector beds should be available during the years of high reliance on non-VA facilities because they will occur before the peak demand period for the aging nonveteran population. The report estimates total VA cost for proposed construction between 1990 and 2020 at amounts ranging from $7 billion to $25 billion in FY85 dollars, more than 95 percent of which would be expended by the year 2000. (Table 9.)

TABLE 9. Projected VA Construction Costs 1990-2020
(millions of 1985 dollars)

Method	1990	2000	2010	2020	Total
District	814.6	5,909.9	225.0	112.5	7,062.0
Metro area	941.6	14,383.6	277.0	112.5	15,714.7
Harris survey	893.6	24,045.4	335.5	112.5	25,387.0

Source: Veterans Administration. Caring for the Older Veteran. July 1984. Part I, appendix II, p. II-6.

Congressional Budget Office Report

At the request of the House and Senate Budget Committees, CBO prepared a study assessing the probable future demand for VA medical care and the resources that will be needed to meet such demand. The report, entitled Veterans Administration Health Care: Planning for Future Years, was released in April 1984. CBO's estimates are based on the assumption that veterans of different age groups will request and receive care in the future at the same rates as today. Unlike the VA report, the CBO report does not include in its estimates of potential future users eligible veterans who are not currently using the system; therefore, CBO's estimates of future need are somewhat lower than those arrived at by the VA. The following is a summary of the report's findings.

Hospital Care

The report estimates the future average daily census of hospital patients and the future need for hospital beds using two different assumptions: (1) that average length of stay (ALOS) will remain the same in the coming years, and (2) that ALOS will continue to decrease gradually until about 1990 as it has over the last several years.

Using the first assumption, that ALOS will remain the same, the CBO report projects that the average daily census of hospital patients will increase from 64,900 in 1982 to about 82,000 in 1990 and 95,000 in the year 2000. It also projects that after 1990 veterans age 65 and over will constitute more than half of VA patients on an average day, about double the proportion in 1982. According to CBO's estimates, in order to accommodate the projected increase in patients, the VA will need about 94,000 hospital beds by 1990--about 14,400 or 18 percent above 1982 levels. By 2000, about 109,000 beds would be needed. (The VA report estimates that between 116,000 and 189,000 hospital beds will be needed by 1990, and from 134,000 to 246,000 by the year 2000.)

Using the second assumption, that ALOS will decrease, CBO estimates that fewer than 60,000 patients will be treated daily in VA hospitals by 1990, and that the VA will need 10,800 fewer hospital beds--a 14 percent reduction from 1982 levels. The need for beds in the year 2000 would be 79,000, approximately the same number of beds as there were at the end of 1982. The report points out, however, that policies that decrease the length of hospital stay would result in increased needs for outpatient and nursing home care.

Nursing Home Care

Assuming that current average hospital lengths of stay remain the same, the CBO report projects that in 1990 the VA will have to support an average daily nursing home census of 34,000 (in VA operated facilities, VA supported State homes, and under contract in community nursing homes), as compared to about 24,400 in 1982. This number is projected to increase to more than 50,000 by the year 2000. (The VA report projects a need for 66,000 to 93,000 VA-operated or supported long-term care beds in 1990 and 102,000 to 131,000 in the year 2000.)

Under the assumption that VA hospital stays will be reduced, even greater increases in demand for nursing home care are projected. CBO estimates that 78 percent of VA nursing home patients in 1990, and about 90 percent in 2000, will be age 65 or older. If the current ratio of placement of veterans in VA and non-VA facilities were continued, CBO estimates that by 1990, about 12,500 nursing home beds will be needed in VA facilities, an increase of about 3,400 or 37 percent over 1982. By the year 2000, nearly 19,000 beds are estimated to be required -- more than double the 1982 number of VA operated nursing home beds. (Table 10.)

TABLE 10. Projections of VA Medical Care in 1990 and 2000

Type of care	Average daily number of patients (thousands)	Number of beds (thousands)
Current hospital average length of stay	1990	
VA hospital	82	94
Nursing home a/	34	35
Domiciliary b/	13	13
	2000	
VA hospital	95	109
Nursing home a/	50	52
Domiciliary b/	13	14
Reduced hospital average length of stay	1990	
VA hospital	60	69
Nursing home a/	39	41
Domiciliary b/	13	14
	2000	
VA hospital	65	79
Nursing home a/	55	58
Domiciliary b/	13	14

a/ The number of nursing home patients and beds represent the overall total of VA-supported patients in VA, community, and State veterans' nursing homes.

b/ The numbers of domiciliary patients and beds represent the total for for VA and State domiciliaries.

Source: Congressional Budget Office. Veterans Administration Health Care: Planning for Future Years. Apr. 1984. p. xvi.

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Other VA Health Care

The CBO report projects that, assuming current usage rates continue, outpatient visits to VA staff will increase from 15.9 million in 1982 to over 16.8 million by 1990. However, if VA hospital lengths of stay were reduced, CBO estimates that the number of outpatient visits to a VA staff could increase to 21 million by 1990.

Under current use rates a need for an additional 500 to 1,000 domiciliary beds in VA and State homes was projected. However, if domiciliary use rates continue to decline, as they have in the past, no additional domiciliary beds would be required.

Costs of Care

The CBO projects that under current ALOS levels, the cost of providing VA medical care (exclusive of construction costs) will increase from about $7.2 billion in 1982 to nearly $9.9 billion in 1990 and $12.6 billion in 2000. These estimates are in 1982 dollars, i.e., they have been adjusted for inflation and represent real cost increases. If no adjustment is made for inflation, under CBO estimates the total cost in 1990 would be $15.4 billion. Nursing home care will experience the most dramatic increases--about 51 percent by 1990 and nearly 130 percent by 2000. Real cost increases would be slightly less under reduced-length-of-stay policies, rising to $9.15 billion in 1990 and $12.3 billion in 2000 (in 1982 dollars). Projected costs of VA medical care are presented in Table 11.

TABLE 11. Projected Costs of VA Medical Care in 1990
(in billions of 1982 dollars)

Type of Care	1982 Actual	1990 Current ALOS a/	1990 Reduced ALOS a/
VA hospital	4.38	6.28	5.20
Nursing home	0.47	0.71	0.79
Domiciliary	0.10	0.13	0.13
Outpatient	1.38	1.70	2.00
Construction b/	0.43	0.85	0.70
Other services	0.85	1.02	1.03
TOTAL	7.60	10.70	9.85

a/ Average length of stay in VA hospitals

b/ The 1990 costs represent the average annual construction costs of new projects begun between 1985 and 1990.

Source: Congressional Budget Office. Veterans Administration Health Care: Planning for Future Years. April 1984. p. xviii.

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CBO Options

The report lists several options for reducing VA medical care costs, including: (1) convert underutilized hospital beds to nursing home beds and convert underutilized hospitals to nursing homes; (2) recover costs from third-party health insurers; (3) provide more care on an outpatient basis; (4) provide more nursing home care in non-VA facilities; (5) restrict eligibility for care to the service-connected disabled and those who meet a strict means test; (6) reduce the scope of services provided; (7) require veterans who are not service- disabled and not-poor to pay for a portion of their care. The CBO estimates that savings from these options could range from $410 million to $3.3 billion by 1990.

CHAPTER IV
ISSUES AND OPTIONS

Several options were available to decision-makers in evaluating the implications of VA and CBO projections of increased demand for VA health care. These were: (1) expand the system to meet anticipated demand; (2) restrict eligibility or limit the scope of benefits provided; and (3) adapt the system so that a greater number of patients, especially geriatric patients, can be served in more cost-efficient ways.

The two which have been favored by policy-makers since the VA and CBO reports were published are reforms in VA eligibility and adaptation of the current system.

Expand The System

Both the VA and CBO reports project that significant increases in VA spending will be required if the VA is to meet the upcoming increased demand for care in the same manner in which it currently provides care. The CBO projects that the VA's FY85 health care budget of approximately $9.1 billion will have to increase to as much as $15.4 billion by 1990, and the VA estimates the cost at between $13.6 and $19.6 billion for that year.

Given the current federal budget deficit, it was and will continue to be unlikely that Congress will approve such increases in the VA budget. In addition, too much expansion of the system could result in under-utilized facilities in later years when the "age bulge" has passed and the demand for VA care is expected to decline. One variation of this "no growth" projection is an expected redirection of resources away from acute to chronic care, consistent with the shift in the health care needs of a growing pool of elderly patients. Most analysts agree that the VA must look to alternatives other than growth of the system.

Restrict Eligibility Or Limit Benefits

Prior to eligibility reforms under the "Omnibus Reconciliation Act of 1985", access to VA care could be restricted through the budget process. The VA was mandated to provide medical care for veterans only to the extent resources were available. Access to the system, therefore, could have been restricted by limiting the amount of money appropriated for VA medical care.

Attempts to severely limit the VA health care budget at a time of increasing demand for VA care, however, would have been met with great resistance from veterans'groups and others. The fact that the Gramm-Rudman-Hollings legislation provides some protection from budget reductions under its provisions for VA medical care testifies to the strong sentiment against program cuts. Reductions in VA medical care under Gramm-Rudman-Hollings were limited to 1 percent in FY 1986 and 2 percent in subsequent fiscal years.

Another option was to limit access to the VA system through enactment of more restrictive eligibility criteria. One such proposal - to establish a "means test" for VA medical care for nonservice-connected disabled veterans - was offered by the Administration as part of the President's FY86 and FY87 budget requests. The Administration's proposal was rejected by both House and Senate Veterans Affairs Committees and subsequently passed in a more liberal form as part of the "Omnibus Budget Reconciliation Act of 1985" (H.R. 3128).

Up until passage of H.R. 3128, veterans over age 65 were eligible for VA care regardless of their financial status. Nonservice-connected disabled veterans under age 65 had to swear that they were unable to pay for care elsewhere. The Administration's means test would deny free VA medical care to nonservice-connected disabled veterans, regardless of age, with incomes in excess of twice the VA pension income standard (about $15,000 per year for a veteran with one dependent) -- an amount more restrictive than that specified in H.R. 3128. Unlike H.R. 3128, the Administration's proposal only required that services be provided as resources were available.

Certain veterans, such as former prisoners of war, World War I veterans, and veterans exposed to Agent Orange or atomic radiation, would be exempted from the income limits. Nonservice-connected disabled veterans with incomes greater than the eligibility limits could become eligible for VA care once their out-of-pocket medical expenses exceed certain amounts.

The means test provision of the budget reconciliation legislation (H.R. 3128) is more liberal than that proposed by the President and provides that the VA must furnish medical care to veterans with service-connected disabilities; former prisoners of war; veterans who have been exposed to Agent Orange or atomic radiation; veterans of World War I and earlier conflicts; and nonservice-connected disabled veterans who, regardless of age, have incomes of $15,000 or less for a single veteran or $18,000 or less for a veteran with one dependent (plus $999 for each additional dependent). Veterans between $15,000 and $20,00 (for single veterans) and between $18,000 and $25,000 (for veterans with one dependent) are eligible for free VA health care on a space available basis.

At the heart of the debate between the Administration's and Veterans Affairs Committees' proposals was the Committees' contention that the VA should be mandated to provide services to a defined group of veterans, including those below specified income levels. Under the Congressional proposal, nonservice-connected disabled veterans with incomes above these income levels can also receive VA medical care - subject to a copayment - if space and resources are available. Those with incomes above $20,000 for a single veteran or $25,000 for a veteran with one dependent (add another $999 for each additional dependent) who receive VA care are required to make a copayment based on the Medicare deductible (estimated at $492 for inpatient care in 1986). The amount of the Medicare deductible is payable for the first 90 days of hospital care, and half of the deductible is payable for each additional 90 days of care within any 12-month period. The maximum deductible payable in any 12-month period is $1230.

Critics of the means test proposals have argued that a means test should not be imposed at this time because there is too little information on what the impact on veterans might be and what amount of money might actually be saved. For instance, they suggest that it is possible that little if any savings to the government would be realized because of added administrative expenses and because costs would be shifted to other federal programs such as Medicare.[24]

Proponents of the Administration's means test argued that the proposal should be enacted to "assure fairness and permit the VA health care system to be more responsive to those veterans with the greatest need for and the highest claim for its services."[25] The House Veterans Affairs Committee, in presenting its alternative to the Administration's proposal argued that "If the population of eligible veterans were clearly defined, and if the (VA) Administrator was required to provide needed health care services to the precisely defined group, a more rational planning process would ensue".[26]

Another cost-saving proposal offered by the Administration and passed in the reconciliation bill, authorizes the VA to collect payment from private health insurance for VA care provided to insured veterans for nonservice-connected conditions. Both CBO and the General Accounting Office (GAO) have estimated significant savings from enactment of such a provision.[27]

Supporters of this proposal contend that under current law insurers receive a "windfall" subsidy when insured veterans receive free VA care. Opponents question the amount of savings that can be achieved given the cost to the VA of developing and administering an appropriate accounting and billing system. They also argue that the proposal would result in increased health insurance premiums across the board, thus unfairly shifting the cost of caring for veterans from the federal government to holders of private health insurance policies.

Adapt The System

Another option for the VA system was and is to make adaptations that will allow it to serve the most people possible in the most cost efficient ways. Even with the change in eligibility introduced by H.R. 3128, the VA is still faced with changes that will allow it to accommodate an increase in the number of patients with chronic illnesses. The VA system, which primarily has been a provider of acute medical care, will have to extend more of resources toward providing long term care and related support services.

Various analysts who have examined the problem have suggested a variety of options for the VA. Some of these are discussed in the following paragraphs.

Increase Geriatric Research, Training and Health Care Programs

The VA already has undertaken major research, training and treatment efforts in the fields of geriatrics and gerontology. In 1974 the VA initiated the Geriatric Research, Education and Clinical Centers (GRECC) program. P.L. 96-330 authorized the VA to set up 15 GRECCs at VA medical centers; 10 have been established as of 1985. Each GRECC conducts research, education and clinical care activities. All the GRECCs investigate general problems of aging, and in addition each focuses on one or more particular areas of geriatric medicine.

In addition to the GRECCs, the VA has been developing Geriatric Evaluation Units (GEUs) in VA hospitals. The GEUs use interdisciplinary health care teams to aid in the proper diagnosis, treatment and placement of geriatric patients. There are currently 45 GEUs operating in VA hospitals.

The VA also offers geriatric physician and geriatric dentist fellowships and provides in-house training in geriatric care for its own personnel.

The VA report calls for expansion of the VA's geriatric programs. By 1990, it said, there should be GEUs in 70 percent of the system's hospitals, and in 100 percent by the year 2000. By 2000 the report states that each VA out-patient clinic should operate a comprehensive medical assessment program in cooperation with a GEU. The report also calls for the expansion of the GRECC program to 30 centers by 1990, and for significant increases in the agency's geriatric research and training efforts.

The VA is ahead of the general health care community in the development of geriatric expertise. This is one area in particular where it is foreseen that the VA can make a great contribution. The VA has the opportunity to serve as a disseminator of information on aging, as a major training site for geriatric professionals, as a magnet for attracting professionals to the field, and as a model system for comprehensive geriatric care.

Increase Use of Noninstitutional Long-Term Care Programs

Because of the projected increase in demand for long-term care and because of the high cost of nursing home care, a second option that has been suggested for the VA is that it should increase its use of noninstitutional long-term care programs.

Although the VA's experience with noninstitutional long-term care is relatively new, the non-VA community health care and social service systems have been experimenting with such programs for a number of years. Federal funding for such programs has been available through Medicaid, Social Services Block Grants, the Older Americans Act, and to a more limited extent, Medicare.

A number of studies have attempted to determine whether noninstitutional care is less costly than institutional care, but to date the results have been inconclusive.

In general, findings seem to indicate that noninstitutional care may be less costly for certain patients with relatively low levels of impairment, but that savings begin to diminish for more highly impaired persons who require more services to remain in the community. In addition, the availability of non-institutional alternatives may actually increase overall health care costs by creating a demand for such services that might not otherwise have existed.

For example, persons who might otherwise have been cared for by family and friends may turn to publicly supported community programs as those services become available.[28] For noninstitutional alternatives to be cost-effective, therefore, such services must be carefully targeted to those patients who might otherwise be at risk of institutionalization but for whom the level of services required can be provided more economically in the community than in a hospital or nursing home.

Cost considerations apart, there is a general consensus that the quality of life is better sustained through noninstitutional programs. The VA report states that a primary objective of any program for the care of the elderly should be "to sustain them in independence, comfort and contentment in their own home environment for as long as possible, providing supportive services required to do so."[29]

Develop A System For Targeting Resources

It has been suggested that the VA should develop a system for targeting its resources to those elderly veterans most at risk of illness, functional disability and dependence. The concept of targeting or "gate-keeping" is fundamental to resource allocation schemes designed to expand service coverage and to control utilization based on the identification of beneficiaries in need or at risk. The Veterans Administration Special Medical Advisory Group (SMAG) - the advisory committee to the VA's aging report - in a 1983 task force report suggested a targeting system based on age (with highest priority for those over age 75 and over), service-connected disability, or receipt of VA pension (i.e., low income).[30]

Convert Acute Care Beds To Extended Care Beds

The CBO and OMB have suggested that the VA might convert some acute care beds to extended care beds or convert some VA hospitals to nursing homes. The CBO said that these options would be cost efficient because on average bed conversions cost less than half the cost of new construction, and because they would reduce the excess supply of hospital beds that exists in some areas.[31]

Increase Use Of Community Resources

Finally, it has been suggested that the VA should increase its use of and collaboration with community health care programs.[32]

The VA report calls for the VA to place more veterans in non-VA nursing homes in the future in order to avoid over-building of VA facilities. It also proposes that the VA make greater use of community noninstitutional programs and services, either through contract purchase of services or through sharing arrangements under which the VA and the community would share in the cost and operation of a program.[33]

The CBO report estimates that placing more veterans in non-VA nursing homes would lower total costs for VA medical care because the VA pays less for contract care than the cost of care in its own facilities.[34]

Currently, about half of the patients for whom the VA provides nursing home care are treated through contract arrangements with community nursing homes. Approximately another 20 percent are cared for in State-operated veterans homes to which the VA makes per diem contributions to cover a portion of the cost of their care.

Concern has been expressed, however, that there are not sufficient community resources available for increased VA usage.[35] Concerns about the availability of community resources stem from the fact that many areas have waiting lists for nursing home beds and community care programs; that many states, in an attempt to control their Medicaid expenditures, have placed moratoria on the construction of new nursing homes; and from fears that, because of fiscal constraints at all levels of government, community programs will not be able to accommodate increased demands from both the veteran and nonveteran populations.

One way that has been suggested to help assure that a complete and adequate supply of facilities and services will be available to both elderly veterans and nonveterans is to increase VA-community coordination in the planning and delivery of services. In the past the VA and community systems have planned and operated with little input from each other. For example, the VA was specifically exempted from a 1974 law (P.L. 93-641) that created State and areawide health planning and resources development authorities.

As often is the case with innovative approaches to service delivery, efforts to coordinate VA and non-VA services developed first through informal arrangements at the local level between VA and non-VA community providers. This "grassroots" approach led in 1985 to the issuance of a directive to field personnel from the VA's national office requiring that a community coordinator be established out of each hospital's social work unit.

In contrast, only recently have serious attempts been made at the national level to examine the relationship of the VA and non-VA systems, the effects that changes in one system have on the other, and the ways in which they can work together to provide a full range of services to the elderly. These efforts include the following.

(1) In 1983, the VA undertook a collaborative effort with Harvard University's Division of Health Policy Research and Education for the purposes of exploring the possibilities for improving integration of VA and community resources for serving the elderly. A conference on this topic was held in October 1983 in Cambridge, Massachusetts, which was attended by top VA officials and representatives of other federal, state and local agencies and organizations involved in planning or delivering services to the elderly.

Specific proposals and options which grew out of the conference were subsequently published in 1984 by the Harvard University Press in a book entitled Older Veterans: Linking VA and Community Resources.[36]

(2) In September, 1984, a conference on long-term care in the United States was jointly sponsored by the VA and the American Health Planning Association. The conference examined problems and progress in the financing and delivery of long-term care in both the VA and non-VA systems. A second conference sponsored by these two groups was held in December, 1985.

(3) The VA report calls for the establishment of Community Collaboration Offices in each VA medical center to serve as a link between VA and community aging programs. The report also calls for the establishment of "seed money" grants to communities to provide start up funding for community-based programs suitable for joint VA-community use.

(4) In April, 1985, a joint hearing was held by the House Select Committee on Aging and the Subcommittee on Hospitals and Health Care of the House Veterans' Affairs Committee. Witnesses at the hearing included representatives of veterans' organizations, community health care providers, academic experts, and VA officials.

There was general agreement among the witnesses at the hearing on two points: first, that both VA facilities and the communities in which they are located can accomplish more with available resources through cooperative efforts than each can do alone; and second, that the VA can serve as a "testing ground" for the rest of the nation in the delivery of health care services to the elderly.

Dr. John Ditzler, Chief VA Medical Director, stated that the VA has the responsibility "to develop and demonstrate effective approaches to the care of older veterans which can be observed and adapted by society at large as the general population ages."[37] Rep. Bob Edgar, Chairman of the Veterans' Affairs Subcommittee on Hospitals and Health Case, and Representative Edward Roybal, Chairman of the House Select Committee on Aging, both endorsed the need to move toward the development of a coherent national policy on health care for the aged -- veterans and non-veterans alike.

The VA and non-VA systems are confronted with a similar dilemma -- an upcoming surge in demand for services in the face of political pressures to cut program costs. The two systems also share common goals of providing a full range of accessible health care and social services to the elderly; of reducing fragmentation of services; of finding effective alternatives to institutionalization; of providing high quality care; and of containing costs.

Each system has something to offer the other. The community has services that could be beneficial to VA clients and the VA has staff, expertise and facilities that could be an important resource for the community. They have a mutual interest, therefore, in collaborating to improve the capacity of each system to deal with the elderly's health care needs.

CHAPTER V
AFTERWORD

It has yet to be seen what impact the recent change in VA eligibility under the "Omnibus Reconciliation Bill of 1985" will have on the VA's ability to meet its commitment to America's veterans. With this change in policy will come new projections of VA demand and of the resources required to meet the VA's new statutory mandate.

Yet, despite efforts to more clearly define the pool of veterans the VA will serve, the move to a balanced budget by 1991 under the Gramm-Rudman-Hollings legislation imposes added constraints on the VA that were not anticipated when the question of a VA means test first arose.

The Gramm-Rudman-Hollings Amendment (currently under review for constitutionality by the courts) requires that the Congress pass a budget within specified deficit targets, leading to a balanced budget by 1991. If it fails to do so, a sequestration process is triggered that imposes automatic, across the board cuts for domestic and defense programs.

While veterans health care and Medicare have limited protection under the Amendment, early estimates project that these programs face potential cuts of 2% in FY87, rising to 9.6% by 1990.[38] Social Security and veterans pensions and compension are exempt from cuts.

Whether or not Gramm-Rudman is upheld by the courts, the issue of the national deficit is expected to continue to dominate debate over public expenditures in the months and years ahead. In this climate, the question of how to meet the needs of aging veterans in an aging society takes on another dimension -- what the country is and is not prepared to afford politically.

From the standpoint of the veteran, the lack of a national policy on aged health care, and long term care in particular, spans both the VA and non-VA sectors. For those veterans eligible for VA care, there is undoubtedly a spouse who is dependent on this country's less comprehensive Medicare system. For the majority of veterans who will never go to the VA for care, they too must rely increasingly on Medicare and their own resources to cover their and their spouse's health care needs. For the veterans eligible for VA care, further budget cuts may compromise the VA's ability to meet its new, albeit more defined mandate.

Veterans, non-veterans and their families share a common stake in health care programs that protect all older Americans. With the VA, we have a relatively comprehensive system whose capacity is challenged by demographic and budgetary constraints. For non-veterans, such a comprehensive system - which began with Medicare and Medicaid - has yet to be completed.

The question that remains is not whether this country can meet its commitment to veterans and to an aging society. It is, instead, whether it will meet this challenge -- a challenge of choice, public voice and political will.

APPENDIX A
VA SYSTEM AND LEGISLATIVE HISTORY

The present VA health care system originated following World War I. Prior to that time federal benefits for veterans consisted mostly of pension benefits. Little in the way of medical or hospital care was provided. A system of national homes for impoverished disabled and aged veterans had been established during the 19th century, but these were mainly custodial facilities that provided only incidental medical care. However, when confronted with 4.7 million returning World War I veterans, many of whom were injured, Congress created several new veterans' benefits programs, including medical care for the service-connected disabled.[39]

In 1921, the Congress established the Veterans Bureau to administer the various veterans' programs.[40] The Veterans Bureau became the Veterans Administration in 1930. The veterans' hospital system was created in 1922 when 57 Public Health Service hospitals that were serving veterans were transferred to the Veterans Bureau.

The hospital system expanded rapidly following World War I because of the emergency need to care for large numbers of war-injured veterans. After the immediate postwar medical needs were met, however, there was excess capacity in veterans' hospitals. Rather than close these facilities, in 1924 Congress passed legislation that would fill excess beds by extending eligibility for hospitalization benefits to indigent veterans with nonservice-connected health needs.[41]

Following World War II, the nation's veteran population swelled to nearly 19 million and the VA system was further expanded and upgraded. Congress extended eligibility for VA care to poor, non-war-injured veterans and increased the scope of medical services offered. In 1946, the Department of Medicine and Surgery within the VA was created and the program of affiliating VA hospitals with medical schools was begun.[42]

Since World War II, the VA has grown into the country's largest health care system. The number and types of veterans served and the scope of medical benefits has continually expanded. Today, for example, nonservice-connected cases comprise a growing proportion of VA patients -- in FY 1983 some 56 percent of patients treated in VA hospitals were treated for conditions unrelated to military service.[47]

The VA has also grown from a primarily acute care hospital system to one providing a full range of health care and rehabilitative services. In addition to its 172 hospitals and 226 outpatient units, the VA directly operates 105 nursing home units, contracts for veteran care with community nursing homes, serves veterans through the State Veteran's Home Program, and operates 16 domiciliaries that provide residential self-care and incidental medical care and support services to chronically ill or disabled veterans.

The VA also has begun to develop a variety of noninstitutional care programs for persons who are eligible for VA care, including the following:

Hospital-Based Home Care: Under this program veterans are cared for in their homes under the supervision of a hospital-based multidisciplinary treatment team. The program is in operation at about 30 medical centers.

Community Residential Care: This program places veterans who are not able to live independently in private "foster" homes. Veterans so placed pay for their own room and board but continue to receive VA medical care. This program is in operation at approximately 120 VA medical centers.

Adult Day Health Care: This program provides medical, social and recreational services to veterans in a group setting during daytime working hours. Adult day health care currently is available at 10 VA medical centers.

Hospice care: There is one formal hospice and palliative care demonstration project in operation at the VA medical center in West Los Angeles, California. This program provides inpatient and home care to terminally ill veterans. In addition, 15 other VA hospitals operate informal inpatient programs.

Respite care: This program allows elderly or disabled veterans to be hospitalized periodically in order to allow a period of relief for those who normally care for the veteran at home. Several VA medical centers have initiated respite care programs.

Legislative Highlights

The following are legislative highlights in the development of the VA medical care system following World War II, especially those with significance for the VA's care of the elderly.

Outpatient Care for Non-Service-Connected Conditions

In 1960, the Congress enacted P.L. 86-639, which for the first time extended outpatient medical services to certain nonservice-connected disabled veterans. Veterans made eligible were those preparing to enter a VA hospital or completing treatment following discharge from a VA hospital.

In 1972, P.L. 93-82 expanded outpatient care for nonservice-connected conditions by including nonservice disabled veterans who are eligible for hospital care and who need outpatient care to obviate the need for hospitalization. P.L. 93-82 also provided that veterans with an 80 percent or more service-connected disability are eligible for outpatient care for any disability. The required degree of disability was subsequently lowered to 50 percent by P.L. 94-581.

These liberalizations in eligibility for outpatient care, in combination with a general medical trend toward greater use of outpatient care, resulted in an increase in VA outpatient medical visits from about 3.5 million in fiscal year 1960 to nearly 19 million in FY 1984 according to VA.

Nursing Home Care

P.L. 88-450, enacted in 1964, for the first time authorized the establishment and operation of nursing home care beds in VA facilities. The legislation also authorized care at VA expense for up to 6 months in community nursing homes for hospitalized veterans who no longer need hospital care but continue to require nursing home care.

P.L. 91-101 eliminated the 6 month limit on community nursing care for the service-connected disabled, and P.L. 93-82 provided that veterans requiring nursing home care for service-connected disabilities may be admitted directly to community nursing homes without first being admitted to a VA hospital. In fiscal year 1984 the VA operated 105 nursing home care units units with nearly 10,000 beds. More than 17,000 nursing home patients were treated by the VA, and over 35,000 patients were treated in community nursing homes at VA expense.

State Veterans' Home Program

P.L. 88-450 authorized the VA to make per diem payments to state veterans' homes providing nursing home care to veterans eligible for VA care. (The VA had been authorized since the late 1800's to make per diem payments for domiciliary and hospital care provided by state veterans' homes.) In fiscal year 1984 the VA made per diem payments for 12,889 veterans receiving state home nursing care, for 8,526 veterans in State home domiciliaries, and for 4,388 veterans treated in state home hospitals.

P.L. 88-450 also established a 50-50 federal-state matching grant program to help States construct new veterans' nursing care facilities, or to expand, remodel or alter existing facilities. Subsequent amendments increased the federal share to 65 percent (P.L. 93-82), and provided the same matching funds for the construction of new state domiciliaries and the expansion, remodelling, and alteration of existing domiciliaries and facilities providing hospital care to veterans (P.L. 95-62).

In FY 1984 the VA obligated about $21.6 million for this grant program. A total of $203,540,000 has been appropriated for the program for fiscal years 1966 through 1985. Of this amount, $149,993,000 had been obligated for 169 projects as of September 30, 1984.

Eligibility of Veterans Age 65 and Over

Public Law 91-500, enacted in 1970, made veterans age 65 and over eligible for VA medical care for nonservice-connected conditions without regard to their ability to defray the cost of care elsewhere. When enacted, this provision was seen as a cost-saving measure because it was believed that most veterans over age 65 would be eligible for Medicare and that the VA could provide care more cheaply than through Medicare reimbursement for care in the private sector.[44]

The assumption that the VA can provide care more cheaply than the private sector has been questioned,[45] but because of noncomparability of data between the two systems, to date this question has not been satisfactorily answered.

With the passage of H.R. 3128, the "Consolidated Omnibus Reconciliation Act of 1985", veterans with nonservice-connected conditions of all ages are now required to meet specified income requirements before becoming eligible for care (refer to discussion in Chapter IV).

Geriatric Research and Care

In 1974, the VA initiated the Geriatric Research, Education and Clinical Centers program. This program established centers--called GRECC's--in selected VA medical facilities to integrate research, education and clinical care activities in the fields of geriatrics and gerontology. The goals of the centers are to improve health care services for older veterans and to attract health care professionals to these fields.

Title III of P.L. 96-330, enacted in 1980, provided statutory authority for the GRECC program. The law authorized the VA to establish up to 15 centers and authorized appropriations through FY 1984. P.L. 98-528 provided permanent authorization for the program.

As of 1985, the VA has established 10 GRECC's. P.L. 96-330 also created a Geriatrics and Gerontology Advisory Committee within the VA's Department of Medicine and Surgery to advise the Chief Medical Director on all matters relating to geriatrics and gerontology, and required that one Assistant Medical Director must be a physician trained in, or having extensive experience in, geriatrics.

Adult Day Health Care

P.L. 98-160 authorized the VA to provide adult day health-care services in VA facilities and through contractual arrangements with non-VA facilities. Veterans eligible for these services include those eligible for transfer from a VA hospital to a community nursing home at VA expense, those who require adult day health-care services primarily for a service-connected disability, and those who are at least 50 percent service-connected disabled. The program is authorized through FY 1988.

Prior to passage of this legislation the VA did provide a limited amount of noninstitutional long-term care, including hospital-based home care and a few adult day care centers, but this legislation emphasized Congressional intent that the VA should provide more in the way of alternatives to institutional care.

APPENDIX B
CITATIONS

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